

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0026112</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Moultrie County Community Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>240 East Street</u> <u>Lovington</u> <u>61937</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Moultrie</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>David M. Jacobus</u> (Title) _____	
Telephone Number: <u>(217) 422-4725</u> Fax # () _____		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Mark S. Wood, CPA</u> (Firm Name & Address) <u>May, Cocagne & King, P.C.</u> <u>1353 E. Mound Road, Suite 300, Decatur, IL 62526</u> (Telephone) <u>(217) 875-2655</u> Fax # <u>(217) 875-1660</u>	
IDPA ID Number: <u>37-1096253001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>2/1/82</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Mark S. Wood, CPA</u> Telephone Number: <u>(217) 875-2655</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Moultrie County Community Center# 0026112 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 3/12/91

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,623</u>			<u>5,623</u>	13
14	TOTALS	<u>5,623</u>			<u>5,623</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.28%

D. How many bed-hold days during this year were paid by Public Aid?

81 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/82

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/82 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Moultrie County Community Center # 0026112 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	36,990	2,075	1,171	40,236		40,236		40,236		1
2	Food Purchase		42,833		42,833	(4,497)	38,336		38,336		2
3	Housekeeping	30,282	4,309		34,591		34,591	179	34,770		3
4	Laundry			1,646	1,646		1,646		1,646		4
5	Heat and Other Utilities			17,679	17,679		17,679	1,311	18,990		5
6	Maintenance	13,000	12,909	22,714	48,623		48,623	3,326	51,949		6
7	Other (specify):*			4,230	4,230		4,230		4,230		7
8	TOTAL General Services	80,272	62,126	47,440	189,838	(4,497)	185,341	4,816	190,157		8
	B. Health Care and Programs										
9	Medical Director			7,400	7,400		7,400		7,400		9
10	Nursing and Medical Records	43,948	2,321	7,884	54,153		54,153	551	54,704		10
10a	Therapy										10a
11	Activities	20,670	7,403		28,073		28,073		28,073		11
12	Social Services	21,224		1,730	22,954		22,954		22,954		12
13	Nurse Aide Training	6,663			6,663		6,663		6,663		13
14	Program Transportation			6,901	6,901		6,901		6,901		14
15	Other (specify):*			137,433	137,433		137,433	(135,634)	1,799		15
16	TOTAL Health Care and Programs	92,505	9,724	161,348	263,577		263,577	(135,083)	128,494		16
	C. General Administration										
17	Administrative	50,750			50,750		50,750		50,750		17
18	Directors Fees										18
19	Professional Services			7,606	7,606		7,606	1,780	9,386		19
20	Dues, Fees, Subscriptions & Promotions			7,212	7,212		7,212		7,212		20
21	Clerical & General Office Expenses	11,500	4,339	16,665	32,504		32,504	(6,210)	26,294		21
22	Employee Benefits & Payroll Taxes			27,630	27,630	4,497	32,127		32,127		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,025	2,025		2,025	1,238	3,263		24
25	Other Admin. Staff Transportation			6,992	6,992		6,992		6,992		25
26	Insurance-Prop.Liab.Malpractice			7,087	7,087		7,087	369	7,456		26
27	Other (specify):*										27
28	TOTAL General Administration	62,250	4,339	75,217	141,806	4,497	146,303	(2,823)	143,480		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	235,027	76,189	284,005	595,221		595,221	(133,090)	462,131		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Moultrie County Community Center

#0026112

Report Period Beginning:

1/1/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,588	20,588		20,588	20,827	41,415			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,549	6,549		6,549	7,790	14,339			32
33	Real Estate Taxes			9,068	9,068		9,068	1,321	10,389			33
34	Rent-Facility & Grounds			45,800	45,800		45,800	(44,400)	1,400			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			82,005	82,005		82,005	(14,462)	67,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,522	32,522		32,522		32,522			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,522	32,522		32,522		32,522			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	235,027	76,189	398,532	709,748		709,748	(147,552)	562,196			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Moultrie County Community Center

0026112

Report Period Beginning:

1/1/00

Ending:

12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(135,634)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,800	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,834)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(20,718)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (20,718)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (147,552)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39	Therapy		X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
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70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Summary A

12/31/00

[illegible]

Summary B

Facility Name & ID Number	Moultrie County Community Center	#	0026112	Report Period Beginning:	1/1/00	Ending:	12/31/00
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Moultrie County Community Center

0026112

Report Period Beginning:

1/1/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
David M. Jacobus	100.00%	Autumn Leaves, Inc. d/b/a Hickory Street Place	Decatur	David Jacobus		Central Office
	100.00%	Autumn Leaves, Inc. d/b/a Beacon Street Place	Decatur	Central Office	Decatur	for homes
	100.00%	Autumn Leaves, Inc. d/b/a 44th Street Place	Decatur			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	21	General Office	\$ 10,000	David Jacobus, Central Office	100.00%	\$ 3,790	\$ (6,210)	1
2	V	3	Housekeeping				179	179	2
3	V	5	Utilities				1,311	1,311	3
4	V	6	Maintenance				3,326	3,326	4
5	V	7	Other				0		5
6	V	10	Medical Supplies				551	551	6
7	V	19	Professional Fees				1,780	1,780	7
8	V	20	Licenses/Dues				0		8
9	V	24	Seminars				1,238	1,238	9
10	V	26	Insurance				369	369	10
11	V	30	Depreciation				4,335	4,335	11
12	V	32	Interest				0		12
13	V	33	Real Estate Taxes				1,321	1,321	13
14	Total			\$ 10,000			\$ 18,200	\$ * 8,200	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.
 ☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Building Rent	\$ 44,400	David Jacobus	100.00%	\$	\$ (44,400)	15
16	V	30 Depreciation				7,692	7,692	16
17	V	32 Interest				7,790	7,790	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 44,400			\$ 15,482	\$ * (28,918)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Moultrie County Community Center # 0026112 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David M. Jacobus	Owner	Various	100.00	31,200	2.5	5.00	Dietary	\$ 6,500	1-1	1
2						5	10.00	Maintenance	13,000	6-1	2
3						2.5	5.00	General Office	11,500	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Moultrie County Community Center# 0026112

Report Period Beginning:

1/1/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization David Jacobus, Central OfficeStreet Address 3650 East William StreetCity / State / Zip Code Decatur, Illinois 62521Phone Number (217) 428-7463Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	General Office	Occupied Bed Days	11,307	2	\$ 7,622	\$ 0	5,623	\$ 3,790	1
2	3	Housekeeping	Occupied Bed Days	11,307	2	360	0	5,623	179	2
3	5	Utilities	Occupied Bed Days	11,307	2	2,636	0	5,623	1,311	3
4	6	Maintenance	Occupied Bed Days	11,307	2	6,689	0	5,623	3,326	4
5	7	Other	Occupied Bed Days	11,307	2	0	0	5,623	0	5
6	10	Medical Supplies	Occupied Bed Days	11,307	2	1,107	0	5,623	551	6
7	19	Professional Fees	Occupied Bed Days	11,307	2	3,579	0	5,623	1,780	7
8	20	Licenses/Dues	Occupied Bed Days	11,307	2	0	0	5,623	0	8
9	24	Seminars	Occupied Bed Days	11,307	2	2,489	0	5,623	1,238	9
10	26	Insurance	Occupied Bed Days	11,307	2	741	0	5,623	369	10
11	30	Depreciation	Occupied Bed Days	11,307	2	8,718	0	5,623	4,335	11
12	32	Interest	Occupied Bed Days	11,307	2	0	0	5,623	0	12
13	33	Real Estate Taxes	Occupied Bed Days	11,307	2	2,657	0	5,623	1,321	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 36,598	\$		\$ 18,200	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Soy Capital Bank		X	1997 Dodge Ram Van	\$559.08	11/19/97	\$ 17,646	\$	11/19/00	9.1100	\$ 213	1	
2	National City Bank		X	Building Loan Purchase-Owner	\$2,649.42	1/5/99	refinanced	85,538	1/5/08	8.5000	7,790	2	
3	Soy Capital Bank		X	1997 Jeep	\$835.78	3/1/00	18,435	11,874	3/1/02	8.2390	735	3	
4												4	
5												5	
	Working Capital												
6	National City Bank		X	Operating Cash	N/A	6/30/00	200,000	83,000	6/30/01	9.5000	5,601	6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,044.28		\$ 236,081	\$ 180,412			\$ 14,339	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 236,081	\$ 180,412			\$ 14,339	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Moultrie County Community Center**# **0026112**

Report Period Beginning:

1/1/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	3,986	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	6,454	2
3. Under or (over) accrual (line 2 minus line 1).	\$	2,468	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	6,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	9,068	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	6,653	8
	1996	6,554	9
	1997	6,538	10
	1998	6,509	11
	1999	6,454	12

2000 accrual based on 1999 taxes			
Central office real estate tax expense of \$ 1,321 is not included in above amounts			

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

5,000

B. General Construction Type:

Exterior

Wood

Frame

Wood w/sprinklers

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility	5,000	1994	\$ 25,000	1
2					2
3	TOTALS	5,000		\$ 25,000	3

Facility Name & ID Number Moultrie County Community Center

0026112

Report Period Beginning:

1/1/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1994	1978	\$ 300,000	\$ 7,692	25	\$ 12,000	\$ 4,308	\$ 84,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Paint & Other Improvements			1986	1,055	56	19	56		824	9
10	Heating System			1986	9,876	520	19	520		7,364	10
11	Bathroom Remodel			1988	1,449	46	20	72	26	886	11
12	Carpet			1989	3,933		6			3,933	12
13	Roof			1990	5,700	181	20	285	104	3,040	13
14	Ramp			1988	925		20	46	46	565	14
15	Fire System			1988	1,237		20	62	62	753	15
16	Cabinets			1991	2,494		20	125	125	1,238	16
17	Doors			1991	1,494		26	57	57	568	17
18	Lights & Exhaust Fan			1991	538		16	34	34	330	18
19	Bathroom Remodel			1992	6,000	190	20	300	110	2,600	19
20	Bathroom Remodel			1992	721	23	20	36	13	315	20
21	Bathroom Remodel			1992	1,000	32	20	50	18	429	21
22	Bathroom Remodel			1992	1,030	33	20	51	18	444	22
23	Landscaping			1992	1,200	71	10	120	49	1,030	23
24	Landscaping			1992	1,200	71	10	120	49	1,030	24
25	Bathroom Remodel			1992	1,159	37	20	58	21	497	25
26	Landscaping			1992	1,700	100	10	170	70	1,445	26
27	Bathroom Remodel			1992	642	20	20	32	12	273	27
28	Bathroom Remodel			1992	3,100	98	20	155	57	1,318	28
29	Landscaping			1992	300	18	10	30	12	255	29
30	Plumbing			1992	3,045	97	25	122	25	995	30
31	Bathroom Remodel			1992	560	18	20	28	10	226	31
32	Plumbing			1993	1,539	49	25	62	13	468	32
33	Landscaping			1993	530	31	10	53	22	393	33
34	Carpet			1993	6,352	61	6		(61)	6,352	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 358,779	\$ 9,444		\$ 14,644	\$ 5,200	\$ 121,571	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Fix Air Conditioner		1993	1,535	68	8	192	124	1,407	9
10		Doors & Windows		1993	690	18	26	26	8	198	10
11		Doors & Windows		1993	2,010	52	26	77	25	566	11
12		Roof		1993	7,300	187	20	365	178	2,585	12
13		Exterior Paint		1994	2,725	243	26	105	(138)	646	13
14		Carpet		1994	2,652	257	6	147	(110)	2,652	14
15		Siding		1994	14,355	368	26	552	184	3,543	15
16		Showers		1994	735	19	20	37	18	221	16
17		Plumbing		1994	2,339	60	5		(60)	2,339	17
18		Lighting & Fixtures		1995	2,601	232	10	260	28	1,539	18
19		Carpet		1995	7,124	380	10	712	332	4,156	19
20		Air Conditioner		1995	1,425	36	8	178	142	980	20
21		Landscaping		1996	2,418	167	10	242	75	1,088	21
22		Furnace		1997	1,979	51	15	132	81	506	22
23		Carpet		1998	8,134	1,601	6	1,356	(245)	2,824	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 58,022	\$ 3,739		\$ 4,381	\$ 642	\$ 25,250	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 73,689	\$ 4,306	\$ 4,204	\$ (102)	3-20 yrs	\$ 46,726	37
38	Current Year Purchases	4,898	511	391	(120)	10-15 yrs	391	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 78,587	\$ 4,817	\$ 4,595	\$ (222)		\$ 47,117	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Program Transportation	1997 Dodge Van	1997	\$ 34,279	\$ 2,383	\$ 4,354	\$ 1,971	4	\$ 30,287	42
43	Transportation	1997 Jeep Cherokee	2000	18,435	3,060	3,457	397	4	3,457	43
44	Transportation	1998 Toyota 4-Runner	2000	26,424	3,060	3,067	7	4	3,067	44
45	Transportation	1997 Toyota 4-Runner	1997		1,775	2,580	805	4		45
46	TOTALS			\$ 79,138	\$ 10,278	\$ 13,458	\$ 3,180		\$ 36,811	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 599,526	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 28,278	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 37,078	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 8,800	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 230,749	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE <u>36</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		6,663		6,663
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 6,663	\$	\$ 6,663
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,663			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	29

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8			
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
					1	Licensed Occupational Therapist		hrs	\$			\$
2	Licensed Speech and Language Development Therapist		hrs									2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs									4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescrpts									9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$		\$	\$		\$			14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,956	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	76,733		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,386		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,734		8
9	Other(specify):	480		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 91,289	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	116,801		15
16	Equipment, at Historical Cost	157,725		16
17	Accumulated Depreciation (book methods)	(164,718)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 109,808	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 201,097	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,372	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	91,839		29
30	Accrued Salaries Payable	6,676		30
31	Accrued Taxes Payable (excluding real estate taxes)	354		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 114,841	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,035		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,035	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 117,876	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 83,221	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 201,097	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 69,852	1
2	Restatements (describe):		2
3	Rounding	13	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 69,865	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	13,356	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 13,356	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 83,221	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 587,470	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 587,470	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education	135,634	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,634	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 723,104	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	189,838	31
32	Health Care	263,577	32
33	General Administration	141,806	33
	B. Capital Expense		
34	Ownership	82,005	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,522	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 709,748	40
41	Income before Income Taxes (line 30 minus line 40)**	13,356	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 13,356	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Moultrie County Community Center**# **0026112**Report Period Beginning: **1/1/00**Ending: **12/31/00**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	6,055	6,055	43,948	7.26	5
6	Nurse Aide Trainees	863	891	6,663	7.48	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,042	2,058	17,692	8.60	9
10	Activity Assistants	460	460	2,978	6.47	10
11	Social Service Workers	1,671	1,671	21,224	12.70	11
12	Dietician	3,946	4,106	36,990	9.01	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	260	260	13,000	50.00	17
18	Housekeepers	3,849	3,957	30,282	7.65	18
19	Laundry					19
20	Administrator	520	520	20,030	38.52	20
21	Assistant Administrator	2,408	2,408	30,720	12.76	21
22	Other Administrative					22
23	Office Manager	130	130	11,500	88.46	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,204	22,516	\$ 235,027 *	\$ 10.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	33	\$ 1,171	1-3	35
36	Medical Director	Fee	7,400	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Fee	1,650	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	82	3,669	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	Fee	1,730	12-3	45
46	Other(specify) <u>Psychologist</u>	Fee	2,400	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 18,020		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7	\$ 165	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7	\$ 165		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	Description	Amount	
Terri Dawson	Administrator	0	\$ 20,030	Workers' Compensation Insurance	\$ 3,359	IDPH License Fee	\$			
Maria Neal	Admin. Asst.	0	30,720	Unemployment Compensation Insurance	2,036	Advertising: Employee Recruitment		6,037		
				FICA Taxes	17,703	Health Care Worker Background Check				
				Employee Health Insurance	3,913	(Indicate # of checks performed _____)				
				Employee Meals	4,497	Miscellaneous Licenses		719		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and subscriptions		456		
				Employee Medical Expense	619					
TOTAL (agree to Schedule V, line 17, col. 1)										
(List each licensed administrator separately.)			\$ 50,750							
B. Administrative - Other										
Description			Amount							
			\$							
TOTAL (agree to Schedule V, line 17, col. 3)			\$							
(Attach a copy of any management service agreement)										
C. Professional Services						G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount		
May, Cocagne & King, P.C.	Accounting/Bookkeeping	\$ 7,450					Out-of-State Travel	\$		
Baker & Lake	Legal	156		N/A						
					</					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,522
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 4,497 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT